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Report of the Secretary-General on the activities of the Office of Internal Oversight Services

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Note by the Secretary-General

1. Pursuant to General Assembly resolution 48/218 B of 29 July 1994 and decision 51/468 B of 13 June 1997, the Secretary-General has the honour to transmit, for the attention of the General Assembly, the attached report, conveyed to him by the Under-Secretary-General for Internal Oversight Services, on the audit of the United Nations health insurance programme.

2. The Secretary-General takes note of its findings and concurs with its recommendations.

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Annex

Report of the Office of Internal Oversight Services on the audit of the United Nations health insurance programme

Summary

A. Introduction

The present report has been issued pursuant to General Assembly decision 51/468 B, which called upon the Office of Internal Oversight Services, following its management audit of United Nations global cargo and motor vehicle insurance programmes (A/51/302, annex), to conduct a further similar audit, which would cover all United Nations insurance programmes.

The health insurance programme involves the provision of medical, hospital and dental services through different insurance plans, the cost of which is shared by the Organization and the participants, the latter including both active staff members and retirees, numbering about 22,000 and 7,000 respectively, in 1997. For the biennium 1996–1997, the cost of the programme, comprising the premiums paid under eight plans, amounted to $251.7 million, of which $148.1 million (59 per cent) represents the Organization's share and $103.6 million the participants' contribution.

B. Results in brief

The audit gave rise to a number of findings, the most significant of which include the following:

- The current plans are excessive in number, and this, along with the significant differences that exist between them in terms of the subsidy offered by the Organization and the extent of the benefits offered, make the programme as a whole difficult to administer and control. The programme should be restructured to make it easier to administer and to ensure that claims and administrative costs are adequately controlled. Outside expertise should be sought to assist in restructuring the programme;

- Despite the fact that the companies contracted to administer the New York plans are remunerated by the United Nations on the basis of the reimbursement claims received from participants, no regular checks have been carried out by the Secretariat to verify the number and dollar value of those claims. Resources should be allocated for regular reviews of the claims in question and subsequent corrective action taken, as necessary, to ensure that they are handled efficiently by the plan administrators and that the latter's claim settlement figures and administrative charges are accurate and reasonable;

- A competitive bidding exercise was initiated in the third quarter of 1997 with respect to the existing Headquarters dental programme. However, since the 1950s, the other health insurance contracts have not been subject to review and competitive bidding in connection with the selection of the plan administrators or with the renewal or modification of their contracts. Appropriate action should be taken without further delay and any related renewal or modification in future should be duly submitted beforehand for review by the Headquarters Committee on Contracts;

- For improved transparency, there is a need to modify the manner in which the programme's income, expenditures and reserves are reported in the Organization's financial statements;
- Appropriate action should be taken to implement the 1991 recommendation of the Advisory Committee on Administrative and Budgetary Questions calling for the use of extrabudgetary funds to finance part of the cost of the after-service health insurance programme.

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I. Introduction

1. Based on the management audit report issued by the Office of Internal Oversight Services (OIOS) on United Nations global cargo and motor vehicle insurance programmes (A/51/302, annex), the General Assembly, in its decision 51/468 B, requested the Secretary-General to entrust the Office of Internal Oversight Services with the conduct of a further similar audit, which would cover all United Nations insurance programmes, including the question of insurance contracts based on international bidding.

2. Pursuant to the General Assembly's request, OIOS has conducted two other audits of United Nations insurance programmes. The first audit, which is covered in the present report, focuses on the Organization's health insurance programme. It was carried out at Headquarters and at Geneva during the period from November 1997 to January 1998. The second audit, the report on which has been issued separately (A/52/1020, annex), focuses on commercial insurance plans, including those dealing with aviation and demining liability, and those covering United Nations property at Headquarters and at four overseas locations.

II. Operation of the health insurance programme

3. The health insurance programme provides medical, hospital and dental services through different insurance plans. The plans' participants include both active staff and retirees, the latter participating through the after-service health insurance programme, at Headquarters and at other duty stations worldwide. There are currently eight plans in the programme, the premiums of which are shared by the Organization and the participants under different cost-sharing formulas.

4. Of the eight plans, five (the New York plans) are administered at Headquarters and cover participants based in New York. They comprise the following: Aetna Open Choice; Blue Cross BlueChoice; Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP); Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser); and Group Health Incorporated Dental Plan (GHI). Another plan, the United Nations Staff Mutual Insurance Society against Sickness and Accident (the Geneva plan), is administered at Geneva and covers staff based at that duty station. The two other plans are the Medical Insurance Plan, covering locally recruited General Service staff and National Officer staff members at designated duty stations away from Headquarters, and the Van Breda plan, covering all other staff at offices away from Headquarters.

5. Of the eight plans, six, the New York plans and the Van Breda plan, operate through the six private insurance companies bearing their names, under separate plan administration contracts. For the New York plans, each contract and related arrangements provide for the company, or plan administrator, to (a) make its network of medical, hospital and/or dental providers available for the participants' use, and (b) process and settle reimbursement claims from the participants for the account of the Organization. For the Van Breda plan, no global network is used, and the main focus of the services provided is on the collection of premiums and the administration of claims. For these services, the plan administrators are paid administrative fees at rates which vary from company to company and which are based in part on the dollar value and/or number of claims processed during each calendar year, with the exception of HIP and Kaiser, which include such fees in the premium. These six plans are administered by the Insurance Section, Office of Programme Planning, Budget and Accounts, at Headquarters. In addition, the Medical Insurance Plan is jointly administered by the Insurance Section and the duty stations at which it operates.

6. The programme's operation as a whole is overseen by the Secretariat's Health and Life Insurance Committee, a policy review body made up of staff and management representatives of the United Nations, the United Nations Development Programme and the United Nations Children's Fund, as well as representatives from the Association of Former International Civil Servants (AFICS).

7. The Geneva plan is jointly administered by the United Nations Office at Geneva and other United Nations agencies located at that duty station. Its day-to-day operations are overseen by an executive committee made up of selected representatives of the staff and their respective parent organizations.

8. For the biennium 1996–1997, the cost of the eight plans amounted to approximately $251.7 million, of which $148.1 million and $103.6 million represent the United Nations and the participants' shares, respectively.

9. As part of the audit, OIOS reviewed how each of the plans, and the programme as a whole, were administered. This gave rise to the following observations.

Nature of the programme

10. The initial observation of OIOS was that the programme is essentially run on a self-insured basis, meaning that all risks of financial loss, which occurs when annual claim settlements exceed annual contributions under any plan, are assumed by the Organization and the participants. Therefore, the audit questioned why the plan administrators, rather than the Organization, seemed to have played a larger role in important decisions regarding the programme, such as determining the extent of benefits or services to be made available, and the amount of premiums to be charged under each plan.

11. *In response, the Office of Programme Planning, Budget and Accounts commented that the plans are monitored and then negotiated annually, and that to the extent that the United Nations "buys in" to a company plan, it redounds to the financial advantage of the Organization. Furthermore, management emphasized that Blue Cross, HIP, Kaiser and GHI are fully insured plans, and that, in the event that the United Nations terminates the plan at expiry of a policy year, the insurance company has the obligation to pay out all claims incurred prior to expiry.*

12. OIOS, however, questions the likelihood of such occurrences and notes that present contractual arrangements allow plan administrators to calculate premium rates on the basis of previous experience and projected contingencies. In addition, OIOS takes note that, upon termination of part of the Blue Cross contract in 1994, the United Nations provided Blue Cross with $300,500, from existing reserves, to pay out claims incurred prior to expiry. This fact, as well as present contractual arrangements with plan administrators, directly conflict with management's view that claims incurred prior to expiry of a contract would be paid by the contractor. Since all risks of financial loss are therefore assumed by the Organization and the participants, OIOS maintains its observation that the health insurance programme is essentially run on a self-insured basis.

Health and Life Insurance Committee-related issues

13. During the biennium 1996–1997, the Health and Life Insurance Committee dedicated a significant portion of its work to the structural changes to the Aetna plan, which went from a traditional indemnity plan to a preferred provider organization (PPO) model, designed to mitigate rising hospital and medical costs. It also commenced work on a comprehensive review of the GHI dental plan with a dental plan survey and a planned request for proposals in early 1998. Therefore, the Committee appeared to have focused its efforts on the New

York plans and OIOS observed that insufficient attention was given to such other important issues as the comparability of benefits under the different plans, the rates of contribution payable by the Organization and participants, the investment of reserves and cost containment methods. In addition, the Committee's reporting responsibility seemed to have been given a lesser priority as it reported only once to the Joint Advisory Committee and this sole report did not contain any information on the financial aspects of the programme.

14. There is a need to redefine the terms of reference of the Health and Life Insurance Committee, to clarify its role in overseeing the programme, its relationship with the Insurance Section and reporting responsibilities to the Joint Advisory Committee and the specific areas it should deal with and make recommendations on. In carrying out its functions, the Health and Life Insurance Committee should seek substantive support as needed, in particular in the form of detailed documentation on various areas of concern.

After-service health insurance programme

15. With regard to the after-service health insurance programme, the audit indicated that no action had been taken on the question of having the programme financed partly from extrabudgetary funds, as recommended in 1990 by the Advisory Committee on Administrative and Budgetary Questions.

Medical Insurance Plan

16. In respect of the Medical Insurance Plan, there is a need for Headquarters to establish procedures to ensure that field offices follow a uniform approach in processing claims and establishing whether the expenditures claimed are acceptable and reimbursable as "reasonable and customary charges". *The response of the Office of Programme Planning, Budget and Accounts to this observation, with which OIOS concurs, is that in order to fulfil this need, it would require both staff resources to oversee and monitor the operations of the Medical Insurance Plan, and travel resources to visit the relevant duty stations.*

Geneva plan

17. Concerning the Geneva plan, the audit indicated that it was adequately developed and monitored and that its Executive Committee played an active role in the determination of benefits, a situation which had a positive impact on the overall control environment. Actuarial reviews were performed in 1988 and 1993, and one was prepared for 1998, in order to determine the general trend of the revenues-expenditures ratio. Only two matters were identified by the audit team as requiring corrective action. Firstly, the contributions of temporary staff members to insurance were not distinguished between the Geneva health insurance plan and the Lloyds of London policy covering death, disability and loss of salary. Therefore, there were uncertainties regarding the amount to be allocated to the Geneva plan and the related United Nations subsidy. Secondly, contrary to general practice, single staff members under the plan received a higher subsidy rate, 57 per cent, than staff with dependents, for whom a 50 per cent rate was applied. With regard to the first issue, there is a need for the policies to be analysed separately and for the United Nations costs to be clearly identified and accounted for.

18. *The Office of Programme Planning, Budget and Accounts agreed with the OIOS observation on the first issue and noted that the plan's Executive Committee would be requested to take action to resolve the allocation of the contributions of temporary staff members.* On the second issue, OIOS believes that the Executive Committee should have the existing rate for single staff aligned with that prevailing for the same group of staff in

the rest of the Secretariat. *In this regard, the Office of Programme Planning, Budget and Accounts noted that the current subsidy rate for single staff was recommended by the Executive Committee on the basis of the 1988 actuarial report, and that the Executive Committee would be requested to ensure that the feasibility and financial impact of a possible change would be examined as part of the 1998 actuarial review.*

III. Differences between the existing insurance plans and related problems

19. As detailed below, the eight insurance plans currently making up the health insurance programme differ from each other in terms of cost; the extent to which that cost is shared between the Organization and the participants; the benefits or services available; the reimbursement rates for claimed expenses and other elements. These differences, along with the number of plans in operation, make the programme as a whole difficult to administer and control. Some of the differences between the plans make the programme inequitable as well, allowing participants in one plan to enjoy more favourable terms and higher subsidies than participants of the same categories and grades under another plan.

20. In terms of the premiums charged and the applicable cost-sharing rates, the features of the plans can be seen from the following table, which reflects the amounts in effect in 1997:

Plans	*Monthly premium rates[a] ($)*	*Participants' contribution (Per cent of "medical net" salary)[b]*	*Organization's contribution (Per cent of total premiums (P) or medical net salary (S))*
New York[c]			
Aetna	890.64	6.16%	66.67% of P
Blue Cross	707.48	4.92%	66.67% of P
HIP	625.35	4.36%	66.67% of P
Kaiser	628.11	4.31%	66.67% of P
Offices away from Headquarters			
Van Breda	356.00	3.60%	50% of P
Van Breda Chile	545.00	5.66%	50% of P
Field offices			
MIP (up to 4 dependants)	Not fixed	1.75%	7% of S
MIP (5 and more dependants)		2.25%	9% of S
Geneva			
United Nations Staff Mutual Insurance Society	Not fixed	3.80%	3.80% of S

[a] *Applicable to a staff member with two or more family members.*

[b] *"Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable.*

[c] *The premium rates for the New York plans include the GHI dental premium.*

21. Based in part on the premium rates shown in the above table, the premiums actually paid by the Organization and the participants under the eight plans for the biennium 1996–1997 amounted to $251.7 million, broken down as follows:

Plan	*Organization's contribution ($ million)*	*Participants' contribution ($ million)*	*Total cost premiums ($ million)*
Aetna	52.1	25.2	77.3
Blue Cross	17.3	10.2	27.5
HIP	3.5	1.5	5.0
Kaiser	0.5	0.3	0.8
GHI	8.2	4.6	12.8
Van Breda	26.0	26.0	52.0
Geneva	34.0	32.2	66.2
MIP	6.5	3.6	10.1
Total	**148.1**	**103.6**	**251.7**

22. According to an analysis of the data provided to OIOS, there appear to be no significant differences, in terms of the actual services or benefits offered, between the four largest plans in the programme. However, these four plans, Aetna, Blue Cross, Van Breda and the Geneva plan, differ from each other in terms of the premium rates and OIOS noted that these differences are attributable to two factors. Firstly, the number of retirees in the plan, on the average, results in the incurrence of higher medical costs than other participants. The second factor is the geographic location of the main group of participants, New York, which has the highest medical costs of all of the locations. The Aetna plan is the most costly, while being only the third largest. The Geneva plan is the largest in terms of participation, however it is less costly than the Aetna plan in terms of total claims processed in 1996 and 1997. The Insurance Section explained this situation by the fact that Aetna is a New York based plan and has the largest percentage of retirees (nearly 46 per cent of the plan's total participants in 1997).

23. The above observations are supported by data summarized in the following two tables. The first table shows, for 1997, the number of retiree and non-retiree participants in the eight plans and how much each of these groups contributed towards the total cost of each plan. The second table shows how much was paid out by the four largest plans in settlement of reimbursement claims during the biennium 1996–1997.

Plan	Total number of participants in 1997 (United Nations, UNDP and UNICEF)				Participants' contributions in 1997 ($ million)			
			Retirees				Retirees	
	Total	Active staff	Number	Per cent of total	Total	Active staff	Amount	Per cent of total
Aetna	6 038	3 276	2 762	45.7	12.54	9.45	3.09	24.6
Blue Cross	2 744	2 604	140	5.1	5.20	5.10	0.10	2.0
HIP/HMO	508	401	107	21.0	0.71	0.65	0.06	8.7
Kaiser/HMO	70	48	22	31.4	0.15	0.14	0.01	8.1
GHI	8 408	6 081	2 327	27.7	2.30	2.01	0.29	12.8
Van Breda	7 470	5 571	1 899	25.4	12.03	10.48	1.55	12.9
Geneva plan	6 956	5 204	1 752	25.2	15.00	12.99	2.01	13.5
MIP	6 634	6 187	447	6.7	2.20	2.16	0.04	1.9
Total	**38 828**	**29 372**	**9 456**	**24.4**	**50.15**	**42.97**	**7.18**	**14.3**

Plan	Total claims processed in 1996–1997 ($ million)
Aetna	71.6
Geneva plan	54.8
Van Breda	37.0
Blue Cross	21.4

24. The OIOS comparative analysis of the plans also showed that differences between the plans appear to make the programme inequitable, allowing certain categories of participants to enjoy more favourable terms than others, as follows:

(a) There are no uniform criteria for, among other elements, the maximum amount reimbursable under the plans. Under the MIP, whose participants are made up mainly of locally recruited General Service staff in most of the field offices, the annual maximum is set at the greater of three times the highest General Service salary at the duty station or $1,000, plus an additional $15,000 for hardship claims (overall amount of approximately $16,000). Under the Van Breda plan, whose participants also consist partly of General Service staff, the maximum, set at $15,000 in 1970, has been raised several times since then and currently amounts to $250,000 per year. The Geneva plan, on the other hand, provides for all staff, a maximum lifetime credit of $120,000, intended only as an element of controlling the plan's cost, with the possibility of payments exceeding this limit;

(b) There is also no uniform policy with regard to the treatment of staff members on temporary appointment. The Van Breda plan has a short-term medical scheme, which also covers temporary staff in New York, which allows such staff members a maximum reimbursement of $20,000 per calendar year or contract period. The Geneva plan provides temporary staff a maximum reimbursement of $8,219 per accident or illness.

25. Based on OIOS findings, there is a need for a restructuring of the programme to make it more equitable and easier to control. The assistance of an outside expert may be required to determine how such a restructuring should be done, a process which, in part, could involve adopting a minimum standard of health insurance coverage, which should be made available to all participants, regardless of category, level and duty station.

26. *The Office of Programme Planning, Budget and Accounts agreed that there is a need to simplify the complex structure of the plans in the programme, but noted that there are limits to such an exercise. For the Headquarters plans, the Insurance Section and the Health and Life Insurance Committee have already begun implementation of a medium-term strategy through the modification of the Aetna plan into a preferred provider organization (PPO), thereby allowing two PPOs, Aetna and Blue Cross, to operate in parallel; then, with the aid of expert consultants, firstly, the redesign of the dental plan, and secondly, the redesign of the entire Headquarters insurance plan coverage with the objective of securing a master policy encompassing PPO and health maintenance organization (HMO) elements. With the Aetna plan already converted in 1997 and the new dental plan implemented in 1998, the current goal is to have the new structure ready for implementation in July of 1999.*

27. OIOS recognizes the significance of these steps, but believes that the reform of the United Nations insurance system should not be limited to Headquarters plans, and that the rationalization should address, to the extent possible, the current differences within the programme, leading to the revision of the present subsidy structure.

IV. Selection, use and monitoring of plan administrators

A. Monitoring and control

28. The audit disclosed certain weaknesses in the monitoring and control of the contracts with the administrators of the New York and Van Breda plans, raising questions about the accuracy and reasonableness of the health care charges and administrative costs reported by those companies.

29. At the time of the audit, except for the Medical Insurance Plan, which was administered on a globally decentralized basis under the coordination of the Insurance Section, claims processing was handled through administrative services contracts with Aetna, Blue Cross, GHI, Kaiser, HIP and Van Breda.

30. The auditors could not obtain information on the amount of administrative fees included in the premiums charged under the Kaiser and HIP plans. *The Office of Programme Planning, Budget and Accounts noted that, owing to the nature of community-rated HMO plans, there is no end-of-year accounting nor separately identified administration fees for such plan models.* OIOS accepts this explanation but would request that the Office of Programme Planning, Budget and Accounts find an alternative means of determining the fees in question. In the absence of this information, the HMO claim amounts reported in the following table are based on actual premiums paid.

31. The fees paid to the other plan administrators amounted to $6.8 million in 1997, which represented approximately 10 per cent of the total claims processed in that year. A breakdown of these charges is shown in the following table.

Claims settled by and administrative charges paid to New York and Van Breda plan administrators in 1997

Plans	*(A) Claims settled in 1997 ($ million)*	*(B) Plan administrators' charges (Percentage of (A))*	
		Per cent	*($ million)*
Aetna	36.1	7.5	2.7
Blue Cross	11.2	11.7	1.3
GHI	5.5	13.5	0.7
Van Breda	18.0	14.0	2.5
Kaiser	0.4	Not available	Not available
HIP	2.3	Not available	Not available
Total	**73.5**		

32. Aetna's administrative fee of $2.7 million, shown in the above table, consists of a claim settlement charge of $1.3 million, the cost of its network of providers estimated at $0.5 million, and a profit of $0.9 million. The claim settlement charge, amounting to 50 per cent of the fee, represents the cost of processing an average of 33 claim transactions per participant per year at approximately $6.60 per transaction. For the other plans, the fee was directly expressed as a percentage of the amount of premium or expected claims. OIOS noted that, although the remuneration of plan administrators depended on the number or amount of claims they processed, no regular checks of those claims were made by the Insurance Section to verify the accuracy and reasonableness of the disbursements reported and administrative fees charged by the administrators.

33. *In response to the last point made above, the Office of Programme Planning, Budget and Accounts stated that: "It would be impossible for the Insurance Section to attempt to analyse hospital billings and other provider fees incurred by plan subscribers without duplicating the claims analysis machinery and related software and data banks, which are a key part of the services provided by plan administrators. We do not agree with the conclusion of the auditors that the inability of the Insurance Section to double-check the plan administrators' claims handling process leads to disincentives to perform well nor with the further comments regarding the inadequate review of claims, fraudulent claims and the passing on of consequent costs in the form of higher premiums. Neither the United Nations nor any other employer has the technical capacity to replicate the fraud detection procedures applied by plan administrators. Fraud detection is one of the key services provided by the plan administrators and paid for in the administrative fee to the company. Indeed, an important criterion in selecting a plan administrator is the quality of its fraud detection procedures".*

34. OIOS reiterates that, as the fees paid to plan administrators depend on the number or amount of claims they process, the Organization should, by any means, verify the accuracy and reasonableness of these charges. The absence of regular verification of claims provides little or no incentive for the administrators to perform at a consistently satisfactory level. This, in turn, could result in, among other things, reimbursement claims not being adequately reviewed and of unreasonable, fraudulent or otherwise questionable claims not being identified and acted upon promptly and properly. The end result of these shortcomings would be more costly reimbursement claims and, to cover them, higher and higher premium rates.

35. OIOS acknowledges *the additional comments of the Office of Programme Planning, Budget and Accounts that, since the required technical capacity is not available internally, a claims audit by an outside auditing firm would be the most consistent approach to checking on the accuracy and reasonableness of claims handling and the performance of plan administrators.*

36. The audit also indicated that the Organization and the participants could have earned higher interest income on the reserves held by Aetna and Blue Cross, for the reasons explained below. Regarding the amount of interest earned on reserves held by Aetna, the Treasury of the United Nations indicated, in an informal memorandum dated 21 March 1996, that "5 per cent in 1995 definitely underperformed the market" and advised recovery of the funds. The Treasury informed OIOS that it was possible to obtain an interest of $720,000 in 1997 from the $12.3 million returned to the Organization by Aetna in June 1997, while Aetna was offering only $520,000. On this basis, OIOS believes that losses occurred in prior years, or at least in 1995 and 1996, which could have been prevented by earlier modification of the contract with Aetna, based on adequate monitoring and control of the reserves. However, OIOS recognizes that the return of the reserves held by Aetna to the United Nations, within the context of the new contract, has benefitted the Organization, and welcomes similar changes with respect to the other health insurance plans where feasible.

37. OIOS found that monitoring procedures were also inadequate in respect of the reserves held by Blue Cross. The Insurance Section had established a fund of $300,500 for Blue Cross to cover outstanding United Nations hospital claims incurred prior to 1 July 1994, but still outstanding as of 30 September 1995. While the amount of the fund was determined based on data provided by the contractor itself, the Insurance Section agreed that Blue Cross would not be obliged to return the unspent portion of the above amount to the United Nations after determining that United Nations hospital claims were no longer receivable. Accordingly, until the OIOS review, this reserve was considered a final settlement with no prospect of return of any eventual unspent portion. *The Office of Programme Planning, Budget and Accounts commented that, while this arrangement is standard practice in the United States, Blue Cross did in fact, at the request of the United Nations, re-examine the claims experience and refunded a balance in the amount of $223,628.*

38. Based on the above findings, OIOS believes there is a need for the Organization to review and closely monitor the work of the plan administrators as a means of (a) ensuring that the expenditures reported and fees charged by them are accurate and reasonable and (b) preventing unjustified cost increases as a result of the inefficient administration of the plans and the inadequate handling of reimbursement claims.

B. Shortcomings in the selection of plan administrators

39. In testing to verify compliance with standard procurement rules, the audit team found no documentary evidence that the Headquarters Committee on Contracts had been consulted in connection with any post-1971 modification or renewal of any of the contracts entered into by the Organization with the plan administrators. This is in violation of United Nations financial rule 110.17, which requires the advice of the Committee on Contracts "in respect of a single requisition or a series of related requisitions totalling" $200,000 or more ($40,000 or more until 1989). There is no question that the above rule is applicable to the contracts for plan administration, the fees for which have increased continuously and substantially since the early 1950s. In 1997 fees amounted to $7.2 million for five contracts (from $42,000 in 1952 for two contracts), with single contracts ranging from $0.7 million to $2.7 million.

40. The audit also disclosed that the plan administration contracts have not been subjected to competitive bidding since 1957, although there have been many occasions since then for obtaining proposals from other contractors. When it was envisaged in 1970 to have a single carrier offering a comprehensive coverage, the Office of the Controller explained in a memorandum the decision not to go for competitive bidding as follows:

> "... satisfactory service could be provided by one or the other of the two organizations (Blue Shield and Aetna) ... which was already acquainted with and known by the United Nations. Moreover, since the medical insurance plans are experience rated and the Organization, in effect, pays the carrier a premium to cover the benefit paid to staff plus an element referred to as retention to cover the carrier's overhead costs, there would be little possible advantage in seeking coverage from another carrier."

In the same memorandum, the Office of the Controller recommended that Aetna be retained to administer the new plan, on the basis that the performance of Blue Shield had been poor, while Aetna had provided quality services.

41. The Office of Programme Planning, Budget and Accounts should ensure compliance henceforth with the financial rules – including those calling for competitive bidding and the prior advice of the Committee on Contracts – regarding any future modification or renewal of the plan administration contracts. *Management agreed that health insurance plans should be secured through competitive bidding and has already adopted this position for all new plans, starting with the new dental plan now in place. In addition, management will examine the appropriate modalities for blending the review of new policies by the Committee on Contracts with the process of the Health and Life Insurance Committee.*

C. Administrative charges

42. According to the audit, having several private companies administer the New York plans – Aetna, Blue Cross, Cigna, HIP and Kaiser – is not particularly beneficial and simply involves costly administrative charges, which could be avoided by reducing the number of plan administrators. Aetna's administrative fee rate of 7.5 per cent of claims is the lowest of the fees charged by the five plans, the other rates ranging between 11.3 and 14 per cent. Aetna charged total fees of $2.7 million in 1997, including $0.5 million for its network of providers. Although Blue Cross did not communicate how its fees were calculated, it is certain that it included the cost of its own provider network, which duplicated the Aetna network.

43. OIOS also noted that the Geneva plan, which is administered directly by the United Nations Office at Geneva and, like Van Breda, which applies a 14 per cent fee rate, processes claims originating from more than a hundred countries, incurred, in 1997, administrative costs which represented only 0.7 per cent of the claims. It is therefore worth identifying and comparing all possible alternatives to the present situation, in order to secure a less costly plan administration system.

44. *Management concurred with the foregoing, but indicated that HMOs are for the most part clinic-oriented and employ their own physicians and that there should not be considered to be a duplication between the networks of HIP and Kaiser, on the one hand, and Aetna and Blue Cross on the other.*

V. Accounting and financial reporting issues

45. The audit disclosed that the programme's operations were not being reported in a sufficiently transparent manner through the financial statements issued by the Office of Programme Planning, Budget and Accounts.

46. Among these financial statements, there was only one, as at 31 December 1996, that clearly pertained to the programme: Statement XX, entitled "United Nations funds held-in-trust, statement of income and expenditure and changes in reserves and fund balances". A detailed review of this statement showed what appeared to be significant discrepancies between a number of figures cited in the statement and the figures OIOS had independently verified. Under two items, "Contributions from staff and the United Nations" and "Claim reimbursements", the OIOS-verified figures were higher, by $77.1 million and $69.3 million, respectively, than the statement figures.

47. In addition to the above findings, OIOS notes that Statement XX does not make any mention of the portion of the health insurance reserves held by the plan administrators. The largest of these unreported reserves were those retained by Aetna, amounting to $12.3 million when they were returned to the United Nations in June 1997. This situation not only meant an inaccurate accounting of the programme's reserves, but also required, when the reserves held by Aetna were returned, an adjustment of the accounts so that the $12.3 million did not appear as if it had been generated only during the year in which it was returned.

48. OIOS believes the existing reporting practice should be changed to ensure transparency and a clear understanding of the programme's financial aspects so that Member States and other concerned readers can properly form relevant opinions or take informed decisions on the subject. What is required, in the opinion of OIOS, is one financial statement showing the income, expenditure and reserve figures for all the plans making up the programme. Perhaps this can be accomplished through the issuance of a modified version of Statement XX, whose existing format already provides for full reporting of the figures pertaining to the Medical Insurance Plan and the Geneva plan.

49. *The Office of Programme Planning, Budget and Accounts agreed with the OIOS findings in this area, stating that "there is some difference in reporting for rate stabilization reserves for the Blue Cross, Aetna, GHI and Van Breda plans compared to the reporting for the other plans included in Statement XX". In explaining the difference in reporting, the Office of Programme Planning, Budget and Accounts noted that the Medical Insurance Plan and Geneva reserves "are administered by the Organization; premiums are collected and reimbursements made directly to claimants by the Organization. For the Blue Cross, Aetna, GHI and Van Breda plans, contractual agreements exist between the Organization and the insurers, who administer the plans including the reimbursement of claims". In order to facilitate processing through the United Nations payroll system for Blue Cross, Aetna, GHI, and Van Breda, "all collections are processed through the United Nations General Fund and payments to carriers made from that fund. Reporting on the collections and payments, therefore, are in the United Nations General Fund. At the end of the financial period, only the difference between collections and payments are reported". Management commented that "in our view, it is not necessary to issue modified version of the accounts statements for 1996", but informed OIOS that the note to Statement XX for the period ended 31 December 1997 has already been modified to provide more clarity about the plans' operations. Management also informed OIOS that, of the $12.3 million refunded in 1997, $9.3 million has been treated as an adjustment to the fund balance in the 1997 financial statements and that the balance has been credited to accounts receivable to offset the accounts receivable reported in the December 1995 accounts.*

VI. Conclusion and recommendations

50. As indicated in the present report, the United Nations health insurance programme, although providing a useful service to its participants, has become unwieldy and complicated with the growth in the number of plans involved and the differences that exist between those plans. Its overall cost to the Organization and the participants has also grown steadily and there is no clear indication whether this trend will continue or can be stopped without adversely affecting the participants' access to a reasonable level of insurance coverage. The following recommendations aim at addressing these concerns and other problem areas identified in the present report:

(a) **AH97/93/1/001**: The programme should be restructured to make it easier to administer and to ensure that related costs are adequately controlled. The assistance of an outside expert may be required to determine how such a restructuring should be done, a process which, in part, could involve (I) reducing the number of plans in operation, and (ii) adopting a standard minimum of health insurance coverage, which should be made available to all participants, regardless of category, level and duty station;

(b) **AH97/93/1/002**: In conjunction with the recommended expert study of the programme, the existing contracts with plan administrators should be re-bid as soon as possible and any contract renewal or modification in future should be duly submitted beforehand for the review of the Headquarters Committee on Contracts;

(c) **AH97/93/1/003**: The Office of Programme Planning, Budget and Accounts should undertake, if necessary with the assistance of outside firms specializing in this task, regular reviews of claims submitted under the Aetna, Blue Cross, Van Breda and Cigna plans, (I) to verify the accuracy and reasonableness of the expenditure reports submitted and the administrative fees charged by the plan administrators in this regard, and (ii) to assess the efficiency and effectiveness with which claims and reserves have been administered under the contracts with those administrators;

(d) **AH97/93/1/004**: The Accounts Division should modify its financial reporting practices to ensure that the status and results of the programme's financial operations are reported in a transparent and easy to understand manner through the Organization's financial statements;

(e) **AH97/93/1/005**: The Office of Programme Planning, Budget and Accounts should take appropriate action to implement the recommendation of the Advisory Committee on Administrative and Budgetary Questions calling for the cost of the programme's after-service health insurance programme to be financed partly from extrabudgetary funds;

(f) **AH97/93/1/006**: The Office of Programme Planning, Budget and Accounts, in consultation with the Health and Life Insurance Committee, should establish procedures to ensure that field offices follow a uniform approach in processing claims under the Medical Insurance Plan and establishing the extent to which the expenditures claimed are acceptable and reimbursable as "reasonable and customary charges". Management should ensure that the necessary resources for travel are provided for site visits;

(g) **AH97/93/1/007**: To resolve the existing uncertainties under the Geneva plan regarding the appropriate allocation of the contributions of temporary staff members between the plan and the death, disability and loss of salary insurance policy with Lloyds of London, a review should be made by the plan's Executive Committee to identify and account for the costs to be borne by the United Nations;

(h) **AH97/93/1/008**: The Executive Committee of the Geneva plan should take appropriate action to align the existing subsidy rate of 57 per cent for single staff members with the rate (50 per cent) prevailing for the same group of staff in the rest of the Secretariat.

(Signed) Karl Th. **Paschke**
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Internal Oversight Services